Electronic Medical Records – A Foundation for Health Reform

Betsy L. Thompson, MD, DrPH
Chief Medical Officer, Region 9
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D2 - EMR In-Depth Seminar - Session 1

Agenda

- Background and Vision for Change
- Foundation of Health Information Technology
- Payment System Reform
- Delivery System Reform
- Putting It All Together
- Q&A

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An Unsustainable Status Quo

- **50 million uninsured Americans**
- **Health insurance premiums for family coverage at a small business increased 85% since 2000**
- **17.6% of our economic output tied up in the health care system**
- **Without reform, by 2040, 1/3 of economic output tied up in health care--15% of GDP devoted to Medicare and Medicaid**
- **Without reform, the number of uninsured would grow to 58 million in 2020***

*Source: Urban Institute: "The Cost of Failure to Enact Health Reform: 2010-2020" March 15, 2010

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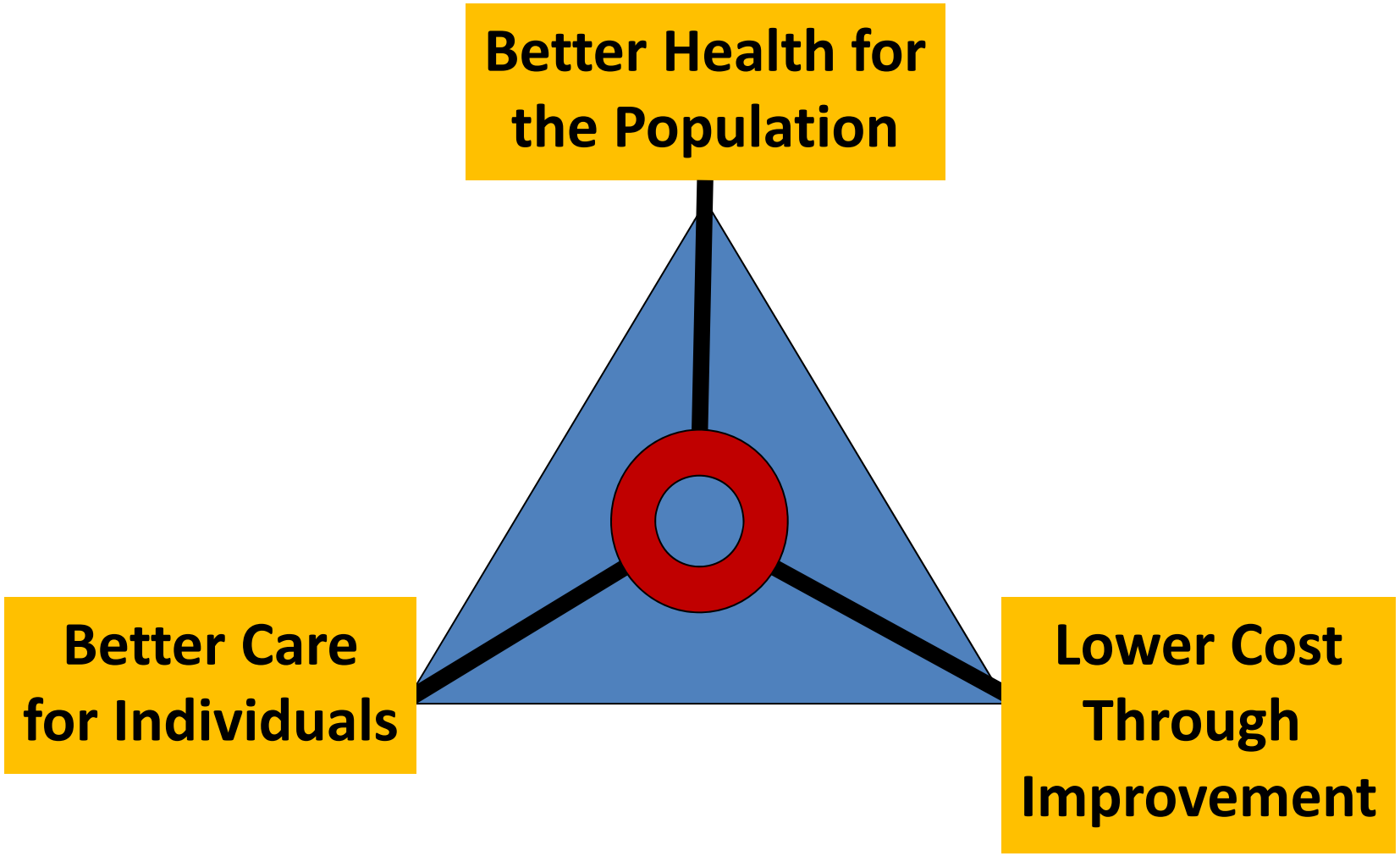
The "Three-Part Aim"



A Future System

- **Affordable**
- **Accessible** – to care and to information
- **Seamless and Coordinated**
- **High Quality** – timely, equitable, safe
- **Person and Family-Centered**
- **Supportive of Clinicians** in serving their patients needs

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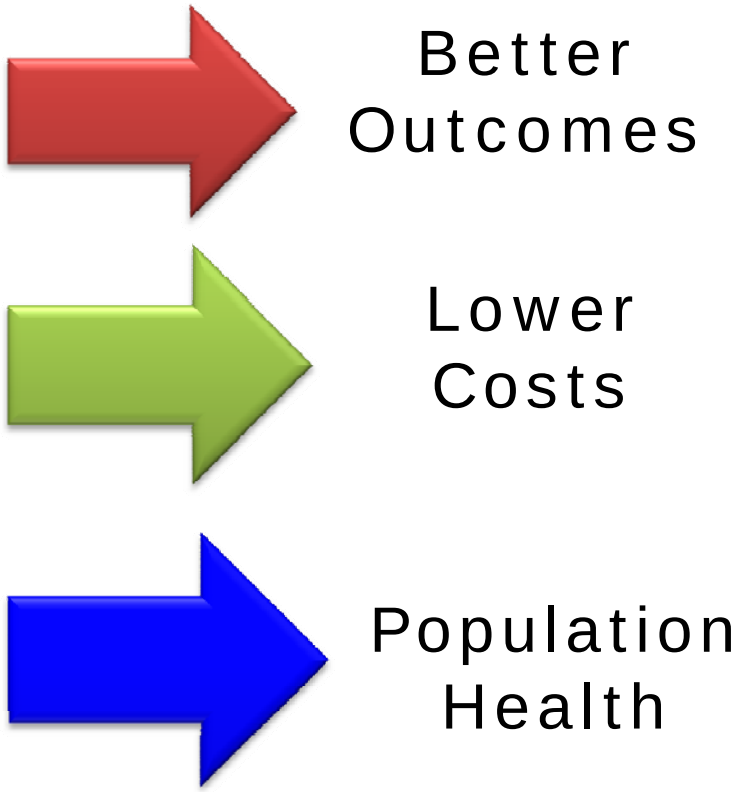
CMS Levers

Incentive Programs	• Quality Reporting Programs • EHR Incentives
Payment Policy	• Accountable Care Organizations • Center for Innovation
Quality Programs	• Partnerships for Patients • Quality Improvement Organizations

Return on Investment from HIT

ROI of EHI at Point of Care:

- Improved Patient Safety
- Reduced Complications Rates
- Reduced Cost per Patient Episode of Care
- Enhanced cost & quality performance accountability
- Improved Quality Performance
- Improve Community Health Surveillance



What is Meaningful Use?

- **Meaningful Use is using certified EHR technology to:**
  - **Improve quality, safety, efficiency, and reduce health disparities**
  - **Engage patients and families in their health care**
  - **Improve care coordination**
  - **Improve population and public health**
  - **All the while maintaining privacy and security**
- **Meaningful Use mandated in law to receive incentives**

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What are the Requirements of Stage 1 Meaningful Use?

Eligible Professionals must complete:

- **15 core objectives**
- **5 objectives out of 10 from menu set**
- **6 total Clinical Quality Measures (3 core or alternate core, and 3 out of 38 from menu set)**

Hospitals must complete:

- **14 core objectives**
- **5 objectives out of 10 from menu set**
- **15 Clinical Quality Measures**

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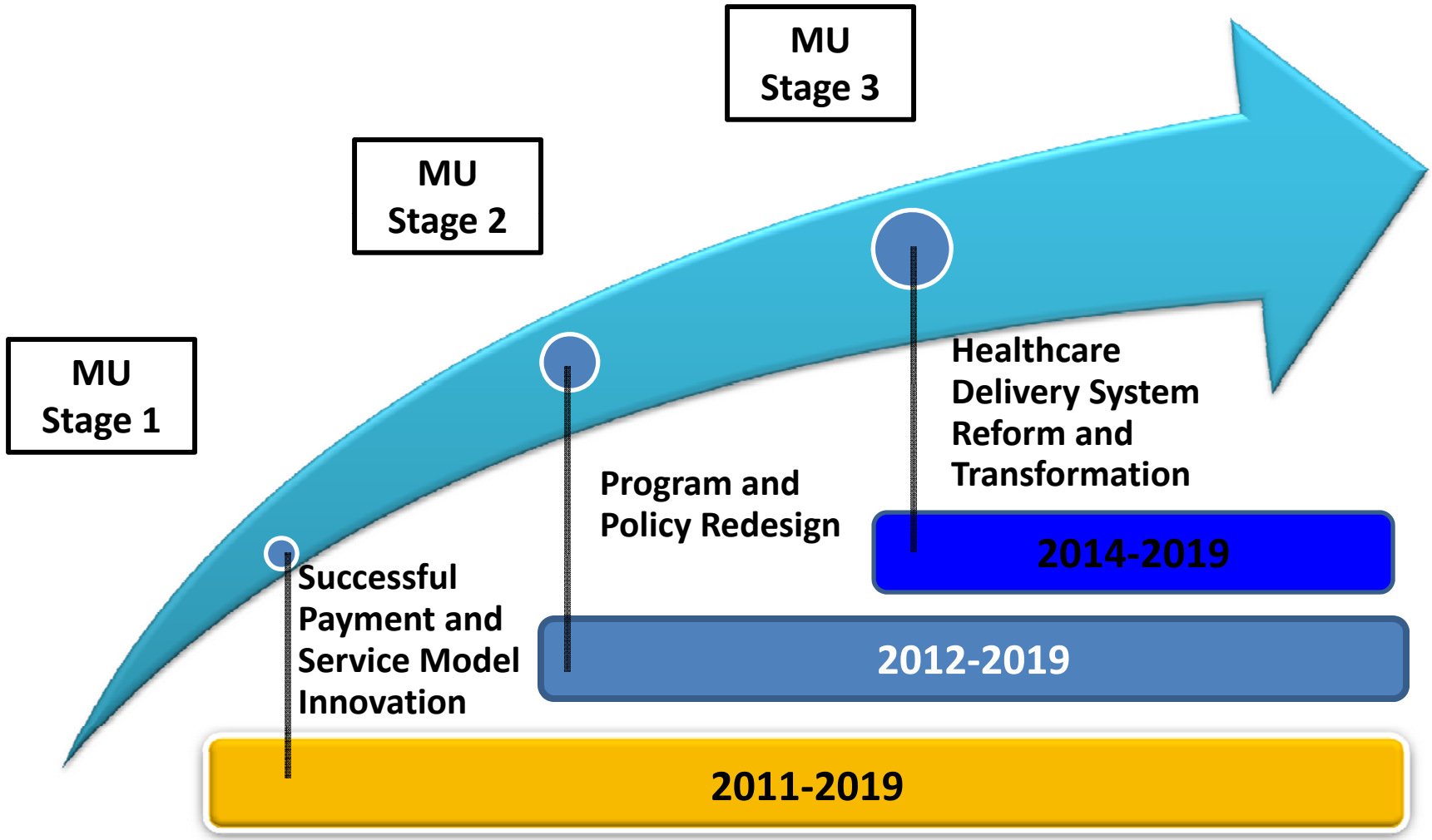
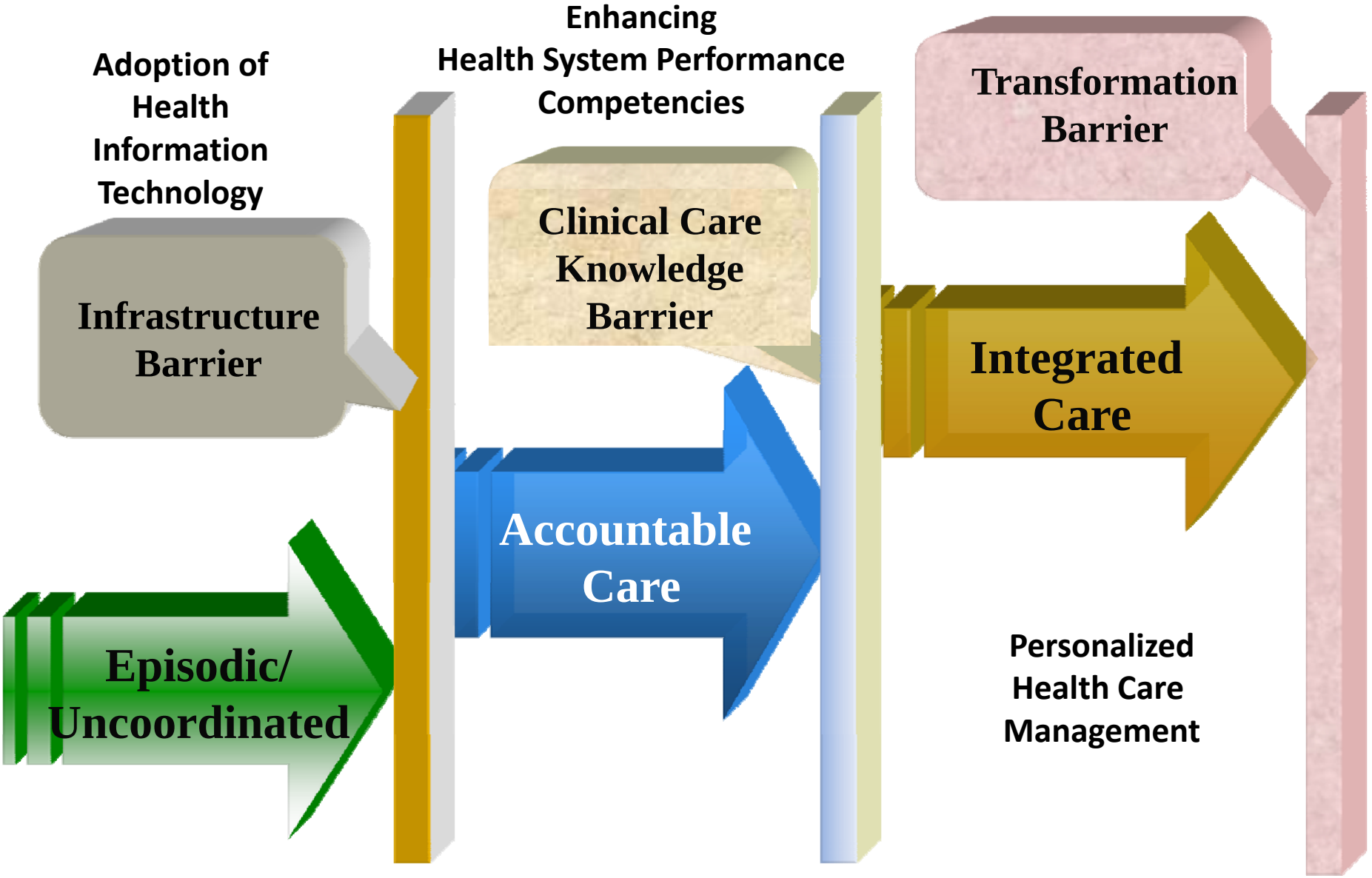
Meaningful Use:
Changes from Stage 1 to Stage 2

Stage 1		Stage 2
Eligible Professionals 15 core objectives 5 of 10 menu objectives 20 total objectives	→	**Eligible Professionals** **17** core objectives **3 of 6** menu objectives 20 total objectives
Eligible Hospitals & CAHs 14 core objectives 5 of 10 menu objectives 19 total objectives	→	**Eligible Hospitals & CAHs** **16** core objectives **3 of 6** menu objectives 19 total objectives

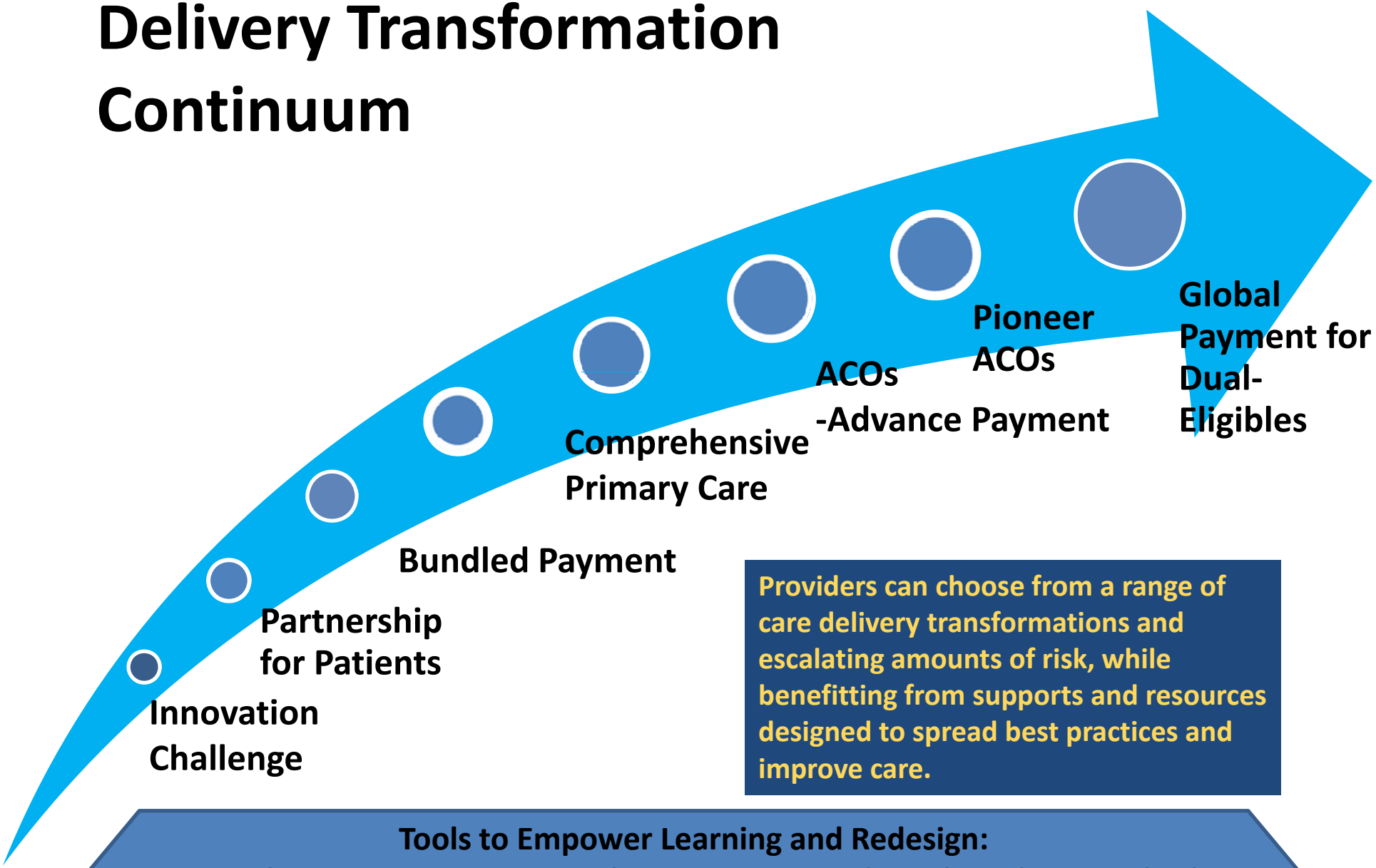
Timeline for Delivery System Reform and Transformation, 2011-2019



Health Care Delivery System Transformation



Delivery Transformation Continuum



Payment System Reforms

- Accountable Care Organizations
- Hospital Value Based Purchasing
- Bundled Payment
- Comprehensive Primary Care Initiative
- Physician Value Based Modifier

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Medicare Shared Savings Program Goals

New approach to the delivery of health care

- **Reduces fragmentation**
- **Improves population health**
- **Lowers overall growth in expenditures by:**
  - **Promoting accountability for care of Medicare fee-for-service beneficiaries**
  - **Improving coordination of care for services provided under Medicare Parts A and B**
  - **Encouraging investment in infrastructure and redesigned care processes**

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The Pioneer ACO Model

GOAL: Test transition from shared-savings payment model to population-based payment

- Designed for health care organizations and providers experienced in coordinating care
- Requires ACOs to create similar arrangements with other payers
- Expected to improve health and care experience for individuals, improve population health, and reduce rate of growth in health care spending
- Performance of Pioneer ACOs will be publicly reported
- 32 Participating ACOs announced in December 2011
- First performance period scheduled to began in January 2012

Advance Payment Model

GOAL: Test whether pre-paying a portion of future shared savings will increase participation and success of physician-based and rural ACOs in Medicare Shared Savings Program

- Payments recouped through shared savings earned by ACO
- Open to ACOs participating in Shared Savings Program

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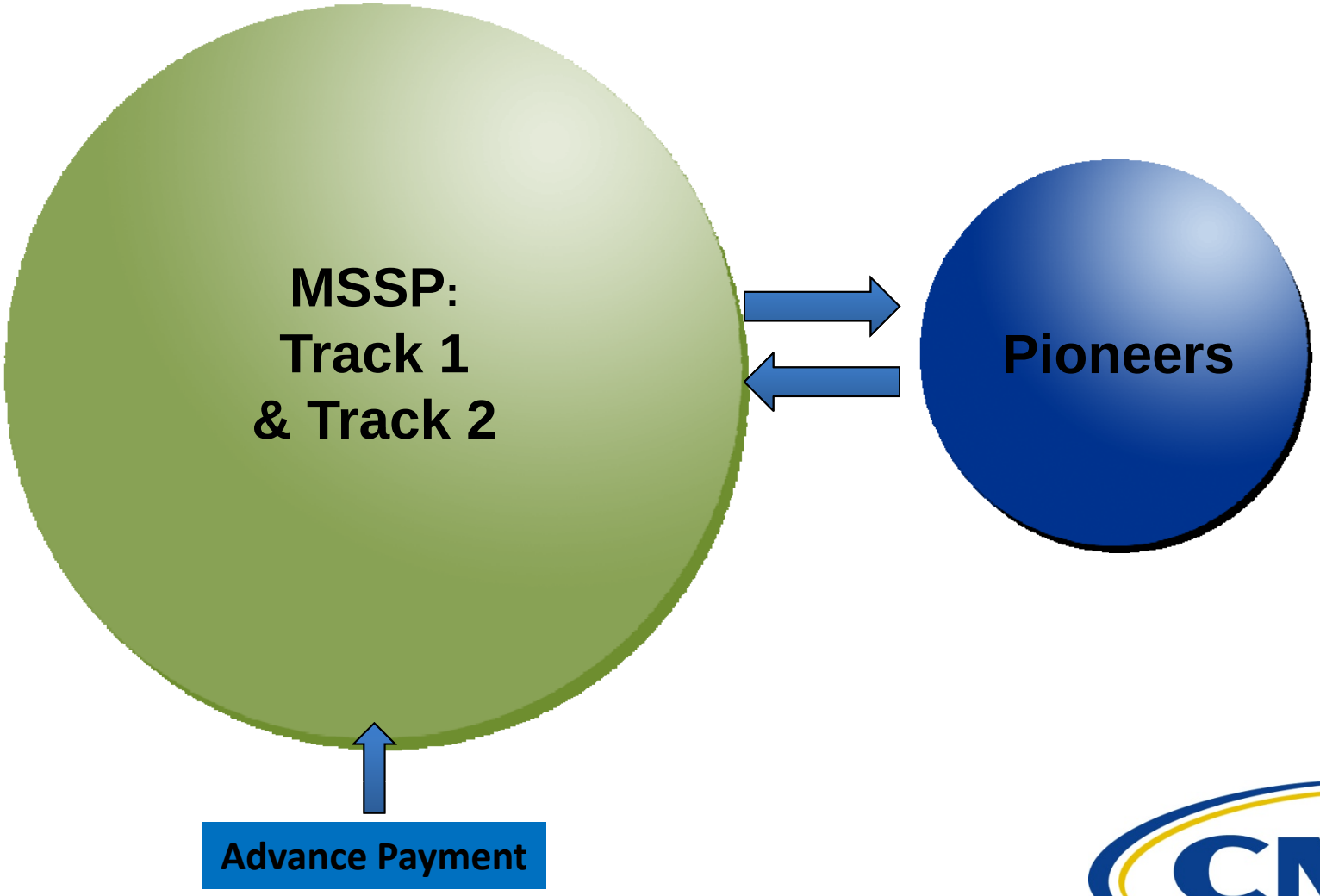
CMS's ACO Strategy: Creating Multiple Pathways with Constant Learning and Improving



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Introduction: Hospital VBP Program

- Required by the Affordable Care Act, which added Section 1886(o) in the Social Security Act
- Quality incentive program built on the Hospital Inpatient Quality Reporting (IQR) measure reporting infrastructure
- Next step in promoting higher quality care for Medicare beneficiaries
- Pays for care that rewards better value, patient outcomes, and innovations, instead of just volume of services
- Funded by the program year reduction from participating hospitals' base-operating Diagnosis-Related Group (DRG) payments
  - 1.25% for FY 2014 and1.50% for FY 2015

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Hospital VBP Program

- **For the first time, 3,500 hospitals across the country will be paid for inpatient acute care services based on care quality.**

- **In FY 2013, an estimated $850 million will be allocated to hospitals based on their overall performance on a set of quality measures that have been shown to improve clinical processes of care and patient satisfaction.**

- **This funding will be taken from what Medicare otherwise would have spent, and the size of the fund will gradually increase over time, resulting in a shift from payments based on volume to payments based on performance.**

- **Funded by a 1% withhold from participating hospitals' Diagnosis-Related Group (DRG) payments raising to 2% by 2017.**

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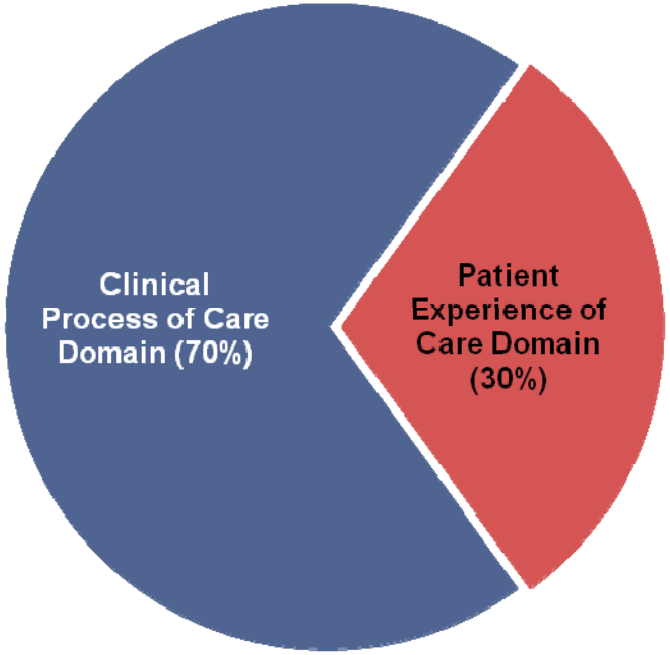
FY2013 HVBP measures

12 Clinical Process of Care Measures

1. AMI-7a Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival
2. AMI-8 Primary PCI Received Within 90 Minutes of Hospital Arrival
3. HF-1 Discharge Instructions
4. PN-3b Blood Cultures Performed in the ED Prior to Initial Antibiotic Received in Hospital
5. PN-6 Initial Antibiotic Selection for CAP in Immunocompetent Patient
6. SCIP-Inf-1 Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision
7. SCIP-Inf-2 Prophylactic Antibiotic Selection for Surgical Patients
8. SCIP-Inf-3 Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery
9. SCIP-Inf-4 Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose
10. SCIP-Card-2 Surgery Patients on a Beta Blocker Prior to Arrival That Received a Beta Blocker During the Perioperative Period
11. SCIP-VTE-1 Surgery Patients with Recommended Venous Thromboembolism Prophylaxis Ordered
12. SCIP-VTE-2 Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis Within 24 Hours

Weighted Value of Each Domain



8 Patient Experience of Care Dimensions

1. Nurse Communication
2. Doctor Communication
3. Hospital Staff Responsiveness
4. Pain Management
5. Medicine Communication
6. Hospital Cleanliness & Quietness
7. Discharge Information
8. Overall Hospital Rating

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How Will Hospitals Be Evaluated?
(FY 2013 Program Summary)

- Two domains:
  - Clinical Process of Care (12 measures)
  - Patient Experience of Care (8 HCAHPS dimensions)
- Hospitals are given points for Achievement and Improvement for each measure or dimension
- Points are added across all measures to reach the Clinical Process of Care domain score
- Points are added across all dimensions and to the Consistency Points to reach the Patient Experience of Care domain score
- 70% of Total Performance Score based on Clinical Process of Care measures
- 30% of Total Performance Score based on Patient Experience of Care dimensions

FY 2014 Finalized Domains and Measures/Dimensions

13 Clinical Process of Care Measures

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9. SCIP-Inf-4 Cardiac Surgery Patients with Controlled 6 a.m. Postoperative Serum Glucose
10. ★ **SCIP–Inf–9 Postoperative Urinary Catheter Removal on Postoperative Day 1 or 2.**
11. SCIP-Card-2 Surgery Patients on a Beta Blocker Prior to Arrival That Received a Beta Blocker During the Perioperative Period
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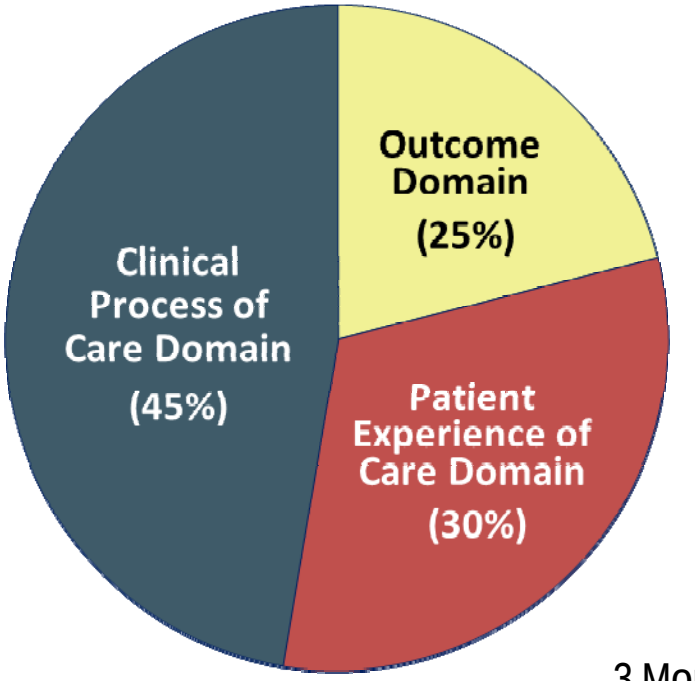
Domain Weights



8 Patient Experience of Care Dimensions

1. **Nurse Communication**
2. **Doctor Communication**
3. **Hospital Staff Responsiveness**
4. **Pain Management**
5. **Medicine Communication**
6. **Hospital Cleanliness and Quietness**
7. **Discharge Information**
8. **Overall Hospital Rating**

3 Mortality Measures ★

1. **MORT-30-AMI Acute Myocardial Infarction (AMI) 30-day mortality rate**
2. **MORT-30-HF Heart Failure (HF) 30-day mortality rate**
3. **MORT-30-PN Pneumonia (PN) 30-day mortality rate**

★ Represents a new measure for the FY 2014 Program not in the FY 2013 Program.

FY 2015 Finalized Domains and Measures/Dimensions

12 Clinical Process of Care Measures

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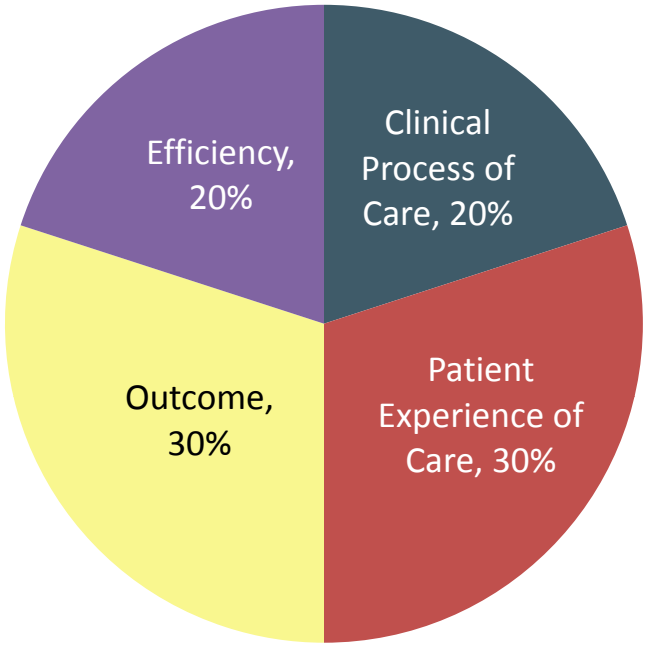

8 Patient Experience of Care Dimensions

1. Nurse Communication
2. Doctor Communication
3. Hospital Staff Responsiveness
4. Pain Management
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8. Overall Hospital Rating

5 Outcome Measures

1. MORT-30-AMI Acute Myocardial Infarction (AMI) 30-day mortality rate
2. MORT-30-HF Heart Failure (HF) 30-day mortality rate
3. MORT-30-PN Pneumonia (PN) 30-day mortality rate
4. PSI-90 Patient safety for selected indicators (composite) ★
5. CLABSI Central Line-Associated Blood Stream Infection ★

1 Efficiency Measure ★

1. MSPB-1 Medicare Spending per Beneficiary measure

★ **Represents a new measure for the FY 2015 program not in the FY 2014 program.**

Hospital Acquired Conditions and Hospital Readmission Reduction Program

- **Hospital Acquired Conditions (Deficit Reduction Act, 2005)**
  - **Began October 1, 2008**
  - **Hospitals no longer receive a higher payment for specified secondary diagnoses not present on admission**
  - **Conditions may be revised over time**
- **Hospital Readmission Reduction Program (Affordable Care Act, 2010)**
  - **Must reduce payments to hospitals with excess readmissions, effective for discharges beginning October 1, 2012**
  - **Initially based on excess readmission ratio for acute myocardial infarction, heart failure and pneumonia**
  - **Maximum of 1% reduction in FY2013, 2% in 2014 and 3% in 2015 and thereafter**

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Bundled Payments for Care Improvement

GOAL: Test effect of "bundling" payments for multiple services that a patient receives during a single episode of care.

Four patient-centered approaches:

- **Acute care hospital stay only**
- **Acute care hospital stay plus post-acute care associated with the stay**
- **Post-acute care only**
- **Prospective payment of all services during inpatient stay**

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Comprehensive Primary Care Initiative

GOAL: Test multi-payer initiative fostering collaboration between public and private health care payers to strengthen primary care

- Requires investment across multiple payers
- CMS invited public and private insurers to collaborate in purchasing high value primary care in communities they serve
- Medicare will pay approximately $20 per beneficiary per month (PBPM) then move towards smaller PBPM combined with shared savings opportunity
- Selected 7 markets where majority of payers commit to investing in comprehensive primary care; approximately 75 practices per market.

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Practice and Payment Redesign through the CPC initiative

SUPPORTIVE MULTIPAYER ENVIRONMENT

Enhanced, accountable payment

Continuous improvement driven by data

Optimal use of health IT

Comprehensive primary care functions:

- Risk-stratified care management
- Access and continuity
- Planned care for chronic conditions and preventive care.
- Patient and caregiver engagement
- Coordination of care across the medical neighborhood

COMPREHENSIVE PRIMARY CARE

Aims:

- *Better health*
- *Better care*
- *Lower costs*

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What is the Value-Based Modifier?

- The Affordable Care Act requires that Medicare phase in a value-based payment modifier (VM) that would apply to Medicare Fee for Service Payments starting in 2015, phase-in complete by 2017.
- The VM assesses both quality of care furnished and the cost of that care.
- Challenging and complex program.
- We propose to apply the VM to physician payment in all groups of 25 or more eligible professionals (EPs) starting in 2015.
- The proposals
  - Encourage physician measurement and alignment with PQRS
  - Offer choice of quality measures and reporting mechanisms
  - Encourage shared responsibility and systems-based care
  - Provide actionable information

What is the Value-Based Payment Modifier (VM)?

- Affordable Care Act requires CMS to phase in a VM
  - Applies to Medicare Fee for Service Payments starting in 2015
  - Phase-in must be complete by 2017

- Must assess both quality of care furnished and the cost of that care

- The proposal:
  - Applies to groups of 25 or more eligible professionals starting in 2015
  - Encourages physician measurement and alignment with PQRS
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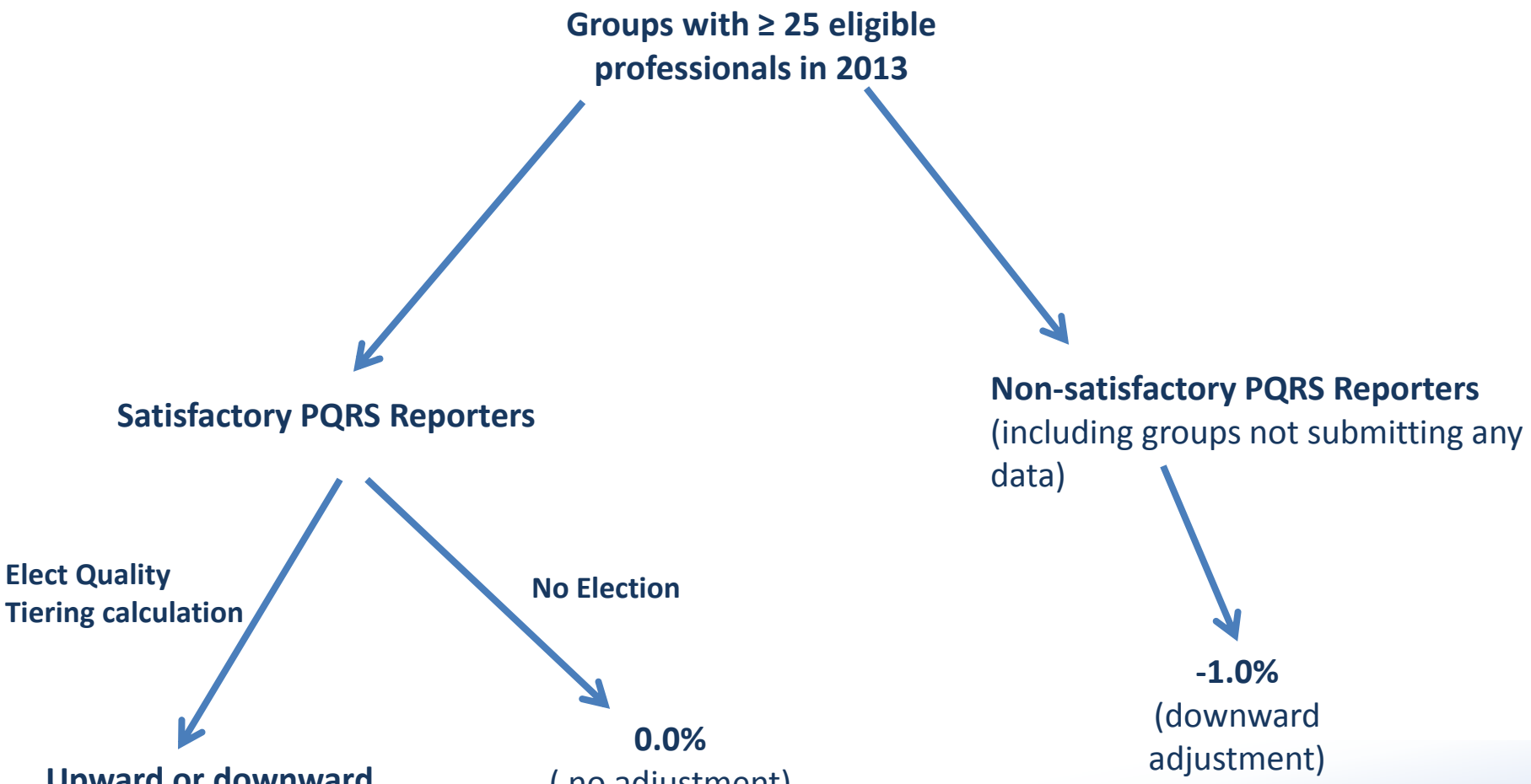
Value Modifier and the Physician Quality Reporting System (PQRS)



Physician Compare: CY 2013 Medicare PFS Proposed Rule

- Continue to expand public reporting of performance information
- Continue to post performance rates on measures that CMS-selected group practices and ACOs report via the GPRO web interface
- Add:
  - 2013 patient experience data for CMS-selected group practices and ACOs
  - Names of participants who earn a 2013 PQRS Maintenance of Certification Program Incentive
  - Measures that have been developed and collected by specialty societies as deemed appropriate
  - 2014 group-level ambulatory care sensitive condition measures of potentially preventable hospitalizations
  - 2015 PQRS and Value-Based Modifier quality measures for individuals

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Delivery System Reforms

- **Partnership for Patients**
- **Million Hearts Campaign**
- **Innovation Advisors Program**
- **Healthcare Innovation Challenge**

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Partnership for Patients: Better Care, Lower Costs

New nationwide public-private partnership to tackle all forms of harm to patients.

GOALS:

40% Reduction in Preventable Hospital Acquired Conditions over three years.

- **1.8 Million Fewer Injuries**
- **60,000 Lives Saved**

20% Reduction in 30-Day Readmissions in Three Years.

- **1.6 Million Patients Recover Without Readmission**
- **$35 Billion Dollars Saved in Three Years**

Improving Patient Safety

GOAL: Testing intensive programs of support hospitals as they make care safer

- Provide national-level content for anyone and everyone
- Support every facility to take part in cooperative learning
- Establish Advanced Participants Network for ambitious organizations to tackle all-cause harm
- Engage patients and families in making care safer
- Improve measurement and data collection, without adding burdens to hospitals

$218 million awarded to 26 organizations to operate hospital networks across the country that will make patient care safer

Million Hearts Campaign

www.millionhearts.hhs.gov

GOAL: Prevent 1 million heart attacks and strokes over next 5 years

Clinical Prevention: improving care of the ABCS through

Focus	simplifying and aligning quality measures; emphasizing importance of improved care of the ABCS'
Health IT	using electronic health records to improve care and enable quality improvement through clinical decision support, patient reminders, registries, and technical assistance.
Care Innovations	team-based care, interventions to promote medication adherence.

Community prevention: reducing the need for treatment through

- Prevention of tobacco use
- Improved nutrition: decreased sodium and artificial trans-fat consumption

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Innovation Advisors Program

GOAL: Support Innovation Center's development and testing of new models of payment and care delivery in home organizations and communities

- Opportunity to deepen key skill sets in:
  - Health care economics and finance
  - Population health
  - Systems analysis
  - Operations research and quality improvement
- 1 year commitment; 6 months of intensive training
- Up to $20K Stipend available to home organizations
- 73 Advisors selected in December 2011
- Up to 200 individuals will be selected within first year
- For further information, see: www.orise.orau.gov/IAP

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Health Care Innovation Challenge

GOAL: Identify and support broad range of innovative service delivery and payment models that achieve better care, better health and lower costs by:

- **Improving care and lowering costs for Medicare, Medicaid, and CHIP beneficiaries**
- **Reaching populations with the greatest health care needs**
- **Rapidly implementing the proposed model**
- **Developing, training, and deploying workforce in support of innovative health care payment and delivery models**

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Health Care Delivery System Transformation

Healthcare Delivery System 1.0

Episodic Non Integrated Care

- Episodic Health Care
  - Sick care focus
  - Uncoordinated care
  - High Use of Emergency Care
  - Multiple clinical records
  - Fragmentation of care
- Lack integrated care networks
- Lack quality & cost performance transparency
- Poorly Coordinate Chronic Care Management

Healthcare Delivery System 2.0

Accountable Care

- Transparent Cost and Quality Performance
  - Results oriented
  - Access and coverage
- Accountable Provider Networks Designed Around the patient
- Focus on care management and preventive care
  - Primary Care Medical Homes
  - Utilization management
  - Medical Management

Healthcare Delivery System 3.0

Integrated Health

- Patient/Person Care Centered
  - Patient/Person centered Health Care
  - Productive and informed interactions between Family and Provider
  - Cost and Quality Transparency
  - Accessible Health Care Choices
- Aligned Incentives for wellness
- Integrated networks with community resources wrap around
- Aligned reimbursement/cost Rapid deployment of best practices
- Patient and provider interaction
  - Aligned care management
  - E-health capable
  - E-Learning resources

A Future System

- **Affordable**
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- **Seamless and Coordinated**
- **High Quality** – timely, equitable, safe
- **Person and Family-Centered**
- **Supportive of Clinicians** in serving their patients needs

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Summary

- **Real health reform dependent on achieving:**
  - **Better care**
  - **Better health**
  - **Lower costs**
- **Requires all of us working together**

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For Additional Information:

- Accountable Care Organizations: https://www.cms.gov/ACO/
- Electronic Health Record Incentive Programs: https://www.cms.gov/EHRIncentivePrograms/
- Hospital Value Based Purchasing: https://www.cms.gov/Hospital-Value-Based-Purchasing/
- Million Hearts Campaign: www.millionhearts.hhs.gov
- Partnership for Patients: http://www.healthcare.gov/center/programs/partnership/join/index.html
- http://partnershippledge.healthcare.gov/
- Department of Health and Human Services' health care reform web site: http://www.healthcare.gov

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Thank You!

betsy.thompson@cms.hhs.gov

415.744.3631